STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN47274

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F0000	This visit was for the Investigation of Complaint IN00099853 and Complaint IN00099962. Complaint IN00099853 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F224, F225, and F226. Complaint IN00099962 - Unsubstantiated due to lack of evidence. Survey dates: November 16, 17, and 18, 2011 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Survey team: Diana Sidell RN, TC Janie Faulkner RN Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 4 Medicaid: 69 Other: 6	F0000	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a DESK REVIEW of compliance for this plan of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 79 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/28/11 by Jennie Bartelt, RN.			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were protected from sexual abuse by another resident and by staff. The deficient practice affected 3 of 5 residents reviewed related to abuse in a sample of 7. (Residents F, A, and G) Resident F was sexually abused by Resident B, the facility failed to ensure Resident B was at the Nurse's Station as planned, and Resident B subsequently sexually abused Resident A. Resident G was not protected from sexual abuse by CNA #1. Findings include: 1. Resident 'F's record was reviewed on	F0223	**F-223 Free from abuse/ involuntary seclusion** The facility's intent is to maintain an environment free from abuse/ involuntary seclusion. A. **ACTIONS TAKEN**: 1. Resident indicated is no longer a resident at the facility. 2. Employee indicated was terminated.	12/17/2011

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	11/17/11 at 4:45 p.m. The record indicated Resident 'F' was admitted with diagnoses that included, but were not limited to, dementia with mood and behavior disturbances, chronic back pain, and high blood pressure. A quarterly minimum data set assessment dated 7/14/11 indicated Resident 'F' was severely impaired - never/rarely made decisions in cognitive skills for daily decision making. Nurse's notes dated 10/30/11 at 1:00 p.m. indicated: "Approximately 11:50 AM, CNA approached this writer stating she saw male resident [with] both hands on resident's breasts. States immediately moved Res to her room. Assessed res... [no] apparent injuries noted from encounter...." Social service follow up on 10/31/11 indicated Resident 'F' was not afraid of anyone in the facility, said her weekend was "fine", and had been placed on 15 minute checks for 72 hours. A Facility report form to the ISDH (Indiana State Department of Health), dated 10/31/11, indicated: "...Immediate Action Taken: Residents immediately separated, head to toe assessments completed on both residents. DNS/ED		B. **OTHERS IDENTIFIED**: 1. All residents have the potential to be affected. 2. Resident interviews completed to ensure that they felt safe in their home as well as free from abuse. 3. 100% audit of the behavior monitoring record completed to identify any other residents with sexual behaviors towards other residents or staff. 4. All staff in-service on, abuse prohibition, reporting, and procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS /SSD or designee with a post test. C. **MEASURES TAKEN**: 1. Any residents identified, care plans / CNA. assignment sheets and current interventions will be reviewed/ updated. 2. All staff in-service on, abuse prohibition, reporting, and	

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	[Director of Nursing Services/Executive Director], resident family, physicians notified. Preventive measures taken: Both residents placed on 15 min checks for 72 hours. [Resident 'B'] moved to another room in center on another unit. ['Resident 'B'] to remain at nurse's station while out of room and under direct supervision of staff while away from unit. Resident care plans and CNA assignment sheets updated. Social services to follow up with both residents for 72 hours." The investigation included a signed statement from CNA #6 dated 10/30/11 at 12:00 p.m.: "[Resident 'B'] was in B - Wing lounge with [Resident 'F']. I came in to finish writing down meal intakes, and [Resident 'B'] had both hands on [Resident 'F's] breast. I removed [Resident 'F'] and informed Nurse." 2. Resident 'A's record was reviewed on 11/17/11 at 2:31 p.m. The record indicated Resident 'A' was admitted with diagnoses that included, but were not limited to, hearing impairment, high blood pressure, dementia, mild cognitive impairment, delirium related to multi-etiology, and agitated depression. A quarterly minimum data set assessment dated 9/26/11 indicated Resident 'A' was able to make self understood and		procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS /SSD or designee with a post test, this will be completed on a monthly basis until discontinued by facility QA committee. 3. Other employee involved in incident has had 1:1 education regarding resident safety and communication. 4. Behavior monitoring tools will be reviewed with IDT team daily during daily clinical QA meeting. 5. Resident incidents will be reviewed daily during daily clinical QA meeting to implement / review/ update any care plans and CNA. assignment sheets or interventions. 6. Audit across all shifts by charge nurse or designee to monitor staff - resident interaction for appropriateness continued until discontinued by CQI committee. D. **HOW MONITORED**: 1. Resident interviews will be completed to monitor for compliance. Also random employee	

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	understands others, had minimal difficulty hearing, used a hearing aid, and was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making. Nurse's notes dated 11/3/11 at 6:35 p.m. indicated: "Called to resident room to find resident ['B'] in bed [with] resident ['A'] her pants were down to ankles and his pants were down but depends were on both residents were embracing each other & making movements with their lower bodies. Residents were separated. Resident states she does not know how her pants got down. Male resident thinks she is his wife. Male resident moved to another wing & is on one-to-one supervision head to toe assessment done on [Resident 'A'] vitals wnl (within normal limits) [no] s/s (signs or symptoms) of distress. Male resident had been observed at nurse's station at 1820 (6:20 p.m.)...." A "Report of Incident /Crime," dated 11/4/11, indicated: "...Brief Description of Incident: Resident ['B'] was found in bed with resident ['A']. Type of Injury/Injuries: None Immediate Action Taken: Residents separated, head to toe assessments completed on both residents. DNS/ED, resident family, and physicians notified. Preventive measures taken:		audits will be completed to ensure staff compliance and understanding of abuse prohibition policy by the SSD/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 2. Any inappropriate behaviors will be reported to the nurse then reviewed in the daily clinical QA meeting. 3. Abuse prohibition and investigation, Abuse prohibition, and psychoactive medication/ behavior management CQI tools will be utilized by CEO/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 4. The Executive Director/Designee will monitor for compliance of audits in the daily QA stand-up meeting. 5. All audit results will be reviewed in the quarterly QA meeting with the Medical Director. **E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:**	

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	[Resident 'A'] was placed on 15 min checks for 72 hours and [Resident 'B'] was placed on 1:1 supervision and moved to another unit. Resident care plans update. [Resident 'B'] sent to behavioral health center on 11/4/11. Abuse training to be completed for all staff." The facility investigation of this incident included a written and signed statement from RN #4: "Was working C-wing with (two CNAs) - [Resident 'B'] on 15 minute checks for recent incident of sexual misconduct [with] female resident was moved to this wing R/T (related to) incident. At 1820 (6:20 p.m.) [Resident 'B'] was at nurses desk observed by nurse & CNA's. I told CNA's was going to take 10 minute break. 7 minutes later was paged by [LPN #5] to C wing. Came back to discover that while CNAs where (sic) laying [another resident] down [Resident 'B'] had wheeled self to [Resident 'A's] room and was in bed with her. Roommate (sic) [name of roommate] went to D wing to get nurse because there was a strange man in bed with her roommate (sic) barking like a dog. [LPN #5] went to the room at 1835 (6:35 p.m.) to find both residents with pants down to ankles. [Resident 'A'] had depend on. I observed both residents embracing each other with arms & moving lower bodies as if having sex no penetration was		**12/17/11.**	

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	observed...we separated residents and took proper steps to ensure safety. DON [Director of Nursing] & social services all family members notified. Head to toe [assessment] done on both [no] injuries. [Resident 'B'] thought [Resident 'A'] was his wife. [Resident 'B'] was taken to D wing and put on one & one supervision...." The facility investigation included a written and signed statement from LPN #5 as follows: "On this date at 1835 (6:35 p.m.) I was working as nurse on "D-Wing" when [Resident 'A's roommate] approached me and asked if I was the nurse for "C-Wing". I informed her I was not, but asked what she needed. She then informed me that "There is a strange man in my room and he is in bed with my room mate." I immediately went to room [number of room] where I found [Resident 'B'] laying in bed with [Resident 'A']. I immediately paged "C-Wing nurse [RN #4] to room. Upon arrival to room I found both [Resident 'B' and Resident 'A'] undressed from the waist down. [Resident 'B'] was still wearing a depends but it was pushed aside so as to appear it had been removed. Together [RN #4] removed [Resident 'B'] from bed, dressed him, placed him in W/C and placed him at nurses station with CNA. Head to toe performed immediately and incident			

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	report initiated. Resident ['B'] was removed from room by approximately 1845 (6:45 p.m.)." Social Service Progress Notes dated 11/4/11 at 6:55 a.m. indicated: "SS visited [with Resident 'A'] at this time. sitting in chair smiling. This writer inquired as to any concerns voices "No" smiling. Writer inquired as to if she had any visitors last night - smiling voices "No". Writer inquired as if anyone had touched her in anyway inappropriately, voices "No". Writer inquired to if she knew year or day, voices "No" writer inquired as to if she felt afraid of, anyone at facility voices No, No S/S of distress noted - pleasant, smiling...." On 11/17/11 at 3:30 p.m., the Social Services Director indicated Resident 'A' has shown no signs of distress from this incident at any time. 3. Resident 'B's record was reviewed on 11/17/11 at 11:05 a.m. The record indicated Resident 'B' was admitted with diagnoses that included, but were not limited to, high blood pressure, non insulin dependent diabetes, senile dementia, chronic renal failure, and colon cancer. An admission assessment dated 8/26/11			

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	indicated Resident 'B' makes self understood, usually understands others, was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making, had an acute change in mental status from the resident's baseline, had behaviors not directed toward others. Nurse's notes with the following dates and times indicated: - 10/30/11 at 11:45 a.m.: "Res found by CNA reported to nurse [with] hands on Res breasts. Res's immediately separated. 15 min [checks] started immediately." - 10/30/11 at 1:00 p.m.: "...Res's move temporarily to D Wing for safety...." - 11/1/11 at 1:00 p.m.: "Res very combative this day - staff attempted to assist up X2 - slapped CNA in face & kept reaching out to grab & hit staff while rendering care...grabbing at staff trying to slap & grab staff breasts." - 11/3/11 at 2:40 a.m.: "Remains on 15 min [checks], in bed resting quietly...." - 11/3/11 at 6:35 p.m.: "Resident [facility number for resident] approached this nurse and stated "There is a strange man in my room and he is laying in bed with my room mate." I immediately left D Wing and upon entering room [number] this resident was found laying in bed [with] resident [facility number for resident]. Paged C-Wing nurse to room.			

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	Residents were separated. This resident still had brief on, assisted with redressing resident. Resident able to stand this nurse & C Wing nurse assisted resident with transferring to w/c due to resident being combative, resident stating "I just want to cuddle [with] my wife". - 11/3/11 at 6:50 p.m.: "Family & MD notified of above [physician] on call for [physician's name] requested order to send [to] behavioral unit...resident moved to D Wing for one to one supervision. Head to toe [assessment] completed...." - 11/4/11 at 1:50 p.m.: "[Name of facility] here to transport Res to [another facility]...." A care plan dated 10/31/11 indicated "Resident touched female peer inappropriately on 10/30/11. Goal: Resident will have not further inapprop. behaviors TNR (through next review). Interventions...(2) temporarily move to D Wing for safety. (3) 15 min [checks] X 72 hours...(6) Res to remain @ nurses station while out of room. (7) direct supervision to be provided by staff when off the unit." A care plan dated 11/4/11 indicated an updated care plan for the episode regarding this resident observed in bed with female peer, and included the intervention to send Resident 'B' to a behavior unit.			

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	On 11/17/11 at 4:25 p.m., the Director of Health Services indicated Psych services had seen Resident 'B' on 9/14/11 to address behaviors and Resident 'B' could remember bits and pieces, but didn't recall exact events. On 11/17/11 at 4:25 p.m., the Executive Director indicated they "had moved him to another room on another hall after the incident on 11-3-11 with [Resident 'A']." 4. Resident 'G's record was reviewed on 11/18/11 at 12:30 p.m. The record indicated Resident 'G' was admitted with diagnoses that included, but were not limited to, high blood pressure, left sided weakness, insomnia, depression, and anxiety. A quarterly minimum data set assessment dated 10/14/11 indicated Resident 'G' had clear speech, made himself understood, understands others, and had modified independence in cognitive skills for daily decision making. Social Service Notes dated 10/7/11 at 8:40 a.m. indicated: "SS [Social Services] spoke [with Resident 'G'] at this time as to any concerns related to his care. [Resident 'G'] voices, on 10/6/11 around			

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	5PM - he was in bed when a CNA patted his bottom and asked him if he liked it - resident voices it made him uncomfortable. And he didn't want it to happen again. Resident voices he didn't want any one in trouble, reassurance provided and assured his concern would be investigated...." A care plan dated 10/7/11 indicated: "Problem: I was patted on my bottom on 10/6/11 it made me feel uncomfortable. Goal: I will be comfortable in my care TNR (through next review) Interventions: (1) Reassure (2) Encourage to vent feelings (3) Notify POA [power of attorney], MD. (4) Resident and POA does not wish to press charges. (5) Calm environment (6) explain procedures prior to care...." A "Facility Incident Reporting Form" dated 10/7/11 indicated: "Brief Description of Incident: [CNA #2] reported during care [CNA #1] patted [Resident 'G'] on the buttocks. Type of Injury/Injuries: None. Immediate Action Taken: [CNA #1 and CNA #2] immediately suspended pending investigation. Preventive measures taken: Shift to Shift 100% all staff inservice on Abuse and Reporting initiated immediately. Results of Investigation: Investigation complete, Staff statements,			

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	resident interviews collected. [CNA #2] reported at the end of her shift at 10 pm to nurse that at approximately 4:30 pm she witnessed [CNA #1] pat [Resident 'G'] on the buttocks and asked him if he liked it and proceeded to pat him again on the buttocks. After interviewing resident, he did state he did not want it to happen again. Plan of Action/Interventions: [CNA #1 and 2] to both be terminated, and Abuse Inservicing." The facility investigation of this incident included a written and signed statement from LPN #3: "[CNA #2] informed me @ approx. 9:55 p.m. (10-6-11) that she needed to talk [with] me while doing a drsg. change on a resident. After I completed my task, I went to nurse's station and began giving report. Shortly after, [CNA #2] came to door way of nurse's station and stood. I got up and went to her. She began telling me she knew she was suppose to report this. I asked her what was going on. She began by telling me that [CNA #1] had made sexual gestures to [Resident 'G']. Said while they were changing him, [CNA #1] began smacking him on the buttocks. She then asked him if he liked it and when he said yes, she did it again. Said at first it was as if she was joking, then a serious look came over he face. I asked [CNA #2] when this happened and she replied			

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	around 4:30 pm that day. I educated [CNA #2] that she needed to report it as soon as it happened so it could be taken care of then, do not wait til (sic) end of shift. Told [CNA #2] to write a statement. Took statement and called DON @ that time." A signed statement from CNA #2 indicated: "[CNA #1] made a sexual gesture toward [Resident 'G']. She smacked him on the buttox (sic) while were changing him and asked him "if he liked it"? He then said yes, and she said "oh really, can I do it again then?" And she did. I witnessed this at approx. 4:30 pm." A signed statement from CNA #1 indicated: "I was turning [Resident 'G'] over to change him. And get him ready for bed. Normally whenever I turn him he is screaming and hollering that I am hurting him. Was surprised that last nite [night] he was not doing any of that. I gently patted or tapped his buttocks, & I asked him if I was hurting him. He said no to do it again. I told him no that I wasn't going to do it. But [Resident 'G'] if I am turning you and using the draw sheet to turn you and you are screaming & hollering at me that I am hurting you, why isn't that patting you don't hurt."			

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	155377	A. BUILDING 00 B. WING	11/18/2011

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	A document titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" with an effective date of 10/17/11, was provided by the Executive Director on 11/17/11 at 10:12 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...Sexual Abuse - includes but is not limited to, sexual harassment, sexual coercion, or sexual assault...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers...." This federal tag relates to Complaint IN00099853. 3.1-27(a)(1)			

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F0224 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure a resident with a history of inappropriate sexual behavior with staff was identified with care planned and implemented interventions to prevent the resident from sexually abusing other residents. The deficient practice affected 3 of 5 residents reviewed related to allegations of sexual abuse in a sample of 7. (Residents B, F and A) Resident B had a history of inappropriate sexual behavior with staff and sexually abused Residents F and A. Findings include: 1. Resident 'B's record was reviewed on 11/17/11 at 11:05 a.m. The record indicated Resident 'B' was admitted with diagnoses that included, but were not limited to, high blood pressure, non insulin dependent diabetes, senile dementia, chronic renal failure, and colon cancer.	F0224	**F-224 Prohibit mistreatment/ neglect/ misappropriation** The facility's intent is to maintain an environment free from mistreatment/ neglect/ misappropriation. A. **ACTIONS TAKEN**: 1. Resident was immediately placed on under 1:1 supervision until being transferred out of facility. 2. Resident indicated is no longer a resident at the facility. B. **OTHERS IDENTIFIED**:	12/17/2011

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	An admission minimum data set assessment dated 8/26/11 indicated Resident 'B' makes self understood, usually understands others, was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making, had an acute change in mental status from the resident's baseline, had behaviors not directed toward others, required extensive assistance of one person for bed mobility and transfers, did not walk, and was independent with moving between locations in his room and adjacent corridor and to and from distant areas on the floor in a wheelchair. Nurse's notes with the following dates and times indicated: - On 8/19/11 at 10:45 p.m.: "When CNA assist. res to B/R (bathroom) & then back to bed res inappositely (sic) pulled his gown up & shook his penis at her asking her if she had ever seen one of these before these before this behavior reported...." - 9/3/11 at 8:30 a.m.: "During med pass this AM, resident touched this nurse between legs and asked "can I have some of that?" then stated to a CNA "can I put this in you?" as he held his penis. Resident instructed that this was inappropriate, will notify SS."		1. All residents have the potential to be affected. 2. Resident interviews completed to ensure that they felt safe in their home as well as free from mistreatment, neglect / misappropriation. 3. 100% audit of the behavior monitoring record completed to identify any other residents with sexual behaviors towards other residents or staff. 4. All staff in-service on, abuse prohibition, reporting, and procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS /SSD or designee with a post test. C. **MEASURES TAKEN**: 1. Any residents identified, care plans / CNA. assignment sheets and current interventions will be reviewed/ updated. 2. All staff in-service on, abuse prohibition, reporting, and procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS	

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	- 10/30/11 at 11:45 a.m.: "Res found by CNA reported to nurse [with] hands on Res breasts. Res's immediately separated. 15 min [checks] started immediately." - 10/30/11 at 1:00 p.m.: "...Res's move temporarily to D Wing for safety...." - 11/1/11 at 1:00 p.m.: "Res very combative this day - staff attempted to assist up X2 - slapped CNA in face & kept reaching out to grab & hit staff while rendering care...grabbing at staff trying to slap & grab staff breasts." - 11/3/11 at 2:40 a.m.: "Remains on 15 min [checks], in bed resting quietly...." - 11/3/11 at 6:35 p.m.: "Resident [facility number for resident] approached this nurse and stated "There is a strange man in my room and he is laying in bed with my room mate." I immediately left D Wing and upon entering room [number] this resident was found laying in bed [with] resident [facility number for resident]. Paged C-Wing nurse to room. Residents were separated. This resident still had brief on, assisted with redressing resident. Resident able to stand this nurse & C Wing nurse assisted resident with transferring to w/c due to resident being combative, resident stating "I just want to cuddle [with] my wife". - 11/3/11 at 6:50 p.m.: "Family & MD notified of above [physician] on call for [physician's name] requested order to send [to] behavioral unit...resident moved to D		/SSD or designee with a post test, this will be completed on a monthly basis until discontinued by facility QA committee. 3. Other employee involved in incident has had 1:1 education regarding resident safety and communication. 4. Behavior monitoring tools will be reviewed with IDT team daily during daily clinical QA meeting. 5. Resident incidents will be reviewed daily during daily clinical QA meeting to implement / review/ update any care plans and CNA. assignment sheets or interventions. 6. Audit across all shifts by charge nurse or designee to monitor staff - resident interaction for appropriateness continued until discontinued by CQI committee. D. **HOW MONITORED**: 1. Resident interviews will be completed to monitor for compliance. Also random employee audits will be completed to ensure staff compliance and understanding of abuse prohibition policy by the	

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	Wing for one to one supervision. Head to toe [assessment] completed...." - 11/4/11 at 1:50 p.m.: "[Name of facility] here to transport Res to [another facility]...." A social service assessment dated 8/27/11 indicated: "...Making sexual comments to female staff and exposing self to staff...socially inappropriate behaviors noted, recent onset...." Social Service Notes, dated 9/20/11 at 8:00 a.m., indicated: "[Resident B] admitted to [psychiatric hospital] 9/19/11 due to increased behaviors, family aware and very involved in care." A care plan, dated 9/5/11, indicated: "I have Behaviors present as evidence by: hitting caregivers in care - resistive. I have Diagnosis: Mental Status change. Goal: My Behaviors will be easily redirected with staff interventions 75 -100% of the [time] thru next review And I will have no injury to self or others TNR (through next review). Interventions: 1. Monitor and observe me for changes in my status 2. Medications as ordered per My Md...5. Psyche services per my request...12. Calm approach calm environment. 14. Provide education as to importance of accepting care."		SSD/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 2. Abuse prohibition and investigation, Abuse prohibition, and psychoactive medication/ behavior management CQI tools will be utilized by CEO/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 3. The Executive Director/Designee will monitor for compliance of audits in the daily QA stand-up meeting. 4. All audits results will be reviewed in the quarterly QA meeting with the Medical Director. **D. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:** **12/17/11.**	

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	A care plan, dated 10/31/11, indicated "Resident touched female peer inappropriately on 10/30/11. Goal: Resident will have not further inapprop. behaviors TNR (through next review). Interventions...(2) temporarily move to D Wing for safety. (3) 15 min [checks] X 72 hours...(6) Res to remain @ nurses station while out of room. (7) direct supervision to be provided by staff when off the unit." A care plan, dated 11/4/11, indicated an updated care plan for the episode regarding this resident observed in bed with female peer, and included the intervention to send Resident 'B' to a behavior unit. On 11/17/11 at 4:25 p.m., the Director of Health Services indicated Psychiatric services had seen Resident 'B' on 9/14/11 to address behaviors and Resident 'B' could remember bits and pieces, but didn't recall exact events. On 11/17/11 at 4:25 p.m., the Executive Director indicated they "had moved him to another room on another hall after the incident on 11-3-11 with [Resident 'A']." 2. Resident 'F's record was reviewed on 11/17/11 at 4:45 p.m. The record indicated Resident 'F' was admitted with diagnoses that included, but were not			

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	limited to, dementia with mood and behavior disturbances, chronic back pain, and high blood pressure. A quarterly minimum data set assessment dated 7/14/11 indicated Resident 'F' was severely impaired - never/rarely made decisions in cognitive skills for daily decision making. Nurse's notes dated 10/30/11 at 1:00 p.m. indicated: "Approximately 11:50 AM, CNA approached this writer stating she saw male resident [with] both hands on resident's breasts. States immediately moved Res to her room. Assessed res... [no] apparent injuries noted from encounter...." Social service follow up on 10/31/11 indicated Resident 'F' was not afraid of anyone in the facility, said her weekend was "fine", and had been placed on 15 minute checks for 72 hours. A Facility report form to the ISDH (Indiana State Department of Health), dated 10/31/11, indicated: "...Immediate Action Taken: Residents immediately separated, head to toe assessments completed on both residents. DNS/ED [Director of Nursing Services/Executive Director], resident family, physicians notified. Preventive measures taken:			

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	Both residents placed on 15 min checks for 72 hours. [Resident 'B'] moved to another room in center on another unit. 'Resident 'B'] to remain at nurse's station while out of room and under direct supervision of staff while away from unit. Resident care plans and CNA assignment sheets updated. Social services to follow up with both residents for 72 hours." The investigation included a signed statement from CNA #6 dated 10/30/11 at 12:00 p.m.: "[Resident 'B'] was in B - Wing lounge with [Resident 'F']. I came in to finish writing down meal intakes, and [Resident 'B'] had both hands on [Resident 'F's] breast. I removed [Resident 'F'] and informed Nurse." 3. Resident 'A's record was reviewed on 11/17/11 at 2:31 p.m. The record indicated Resident 'A' was admitted with diagnoses that included, but were not limited to, hearing impairment, high blood pressure, dementia, mild cognitive impairment, delirium related to multi-etiology, and agitated depression. A quarterly minimum data set assessment dated 9/26/11 indicated Resident 'A' was able to make self understood and understands others, had minimal difficulty hearing, used a hearing aid, and was moderately impaired - decisions poor;			

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	cues/supervision required in cognitive skills for daily decision making. Nurse's notes dated 11/3/11 at 6:35 p.m. indicated: "Called to resident room to find resident ['B'] in bed [with] resident ('A') her pants were down to ankles and his pants were down but depends were on both residents were embracing each other & making movements with their lower bodies. Residents were separated. Resident states she does not know how her pants got down. Male resident thinks she is his wife. Male resident moved to another wing & is on one-to-one supervision head to toe assessment done on [Resident 'A'] vitals wnl (within normal limits) [no] s/s (signs or symptoms) of distress. Male resident had been observed at nurse's station at 1820 (6:20 p.m.)...." A "Report of Incident /Crime," dated 11/4/11, indicated: "...Brief Description of Incident: Resident ['B'] was found in bed with resident ['A']. Type of Injury/Injuries: None Immediate Action Taken: Residents separated, head to toe assessments completed on both residents. DNS/ED, resident family, and physicians notified. Preventive measures taken: [Resident 'A'] was placed on 15 min checks for 72 hours and [Resident 'B'] was placed on 1:1 supervision and moved			

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	to another unit. Resident care plans update. [Resident 'B'] send to behavioral health center on 11/4/11. Abuse training to be completed for all staff." The facility investigation of this incident included a written and signed statement from RN #4: "Was working C-wing with (two CNAs) - [Resident 'B'] on 15 minute checks for recent incident of sexual misconduct [with] female resident was moved to this wing R/T (related to) incident. At 1820 (6:20 p.m.) [Resident 'B'] was at nurses desk observed by nurse & CNA's. I told CNA's was going to take 10 minute break. 7 minutes later was paged by [LPN #5] to C wing. Came back to discover that while CNAs where (sic) laying [another resident] down [Resident 'B'] had wheeled self to [Resident 'A's] room and was in bed with her. Roommate (sic) [name of roommate] went to D wing to get nurse because there was a strange man in bed with her roommate (sic) barking like a dog. [LPN #5] went to the room at 1835 (6:35 p.m.) to find both residents with pants down to ankles. [Resident 'A'] had depend on. I observed both resident's embracing each other with arms & moving lower bodies as if having sex no penetration was observed...we separated resident's and took proper steps to ensure safety. DON & social services all family members			

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	notified. Head to toe [assessment] done on both [no] injuries. [Resident 'B'] thought [Resident 'A'] was his wife. [Resident 'B'] was taken to D wing and put on one & one supervision...." The facility investigation included a written and signed statement from LPN #5 as follows: "On this date at 1835 (6:35 p.m.) I was working as nurse on "D-Wing" when [Resident 'A's roommate] approached me and asked if I was the nurse for "C-Wing". I informed her I was not, but asked what she needed. She then informed me that "There is a strange man in my room and he is in bed with my room mate." I immediately went to room [number of room] where I found [Resident 'B'] laying in bed with [Resident 'A']. I immediately paged "C-Wing nurse [RN #4] to room. Upon arrival to room I found both [Resident 'B'] and Resident 'A'] undressed from the waist down. [Resident 'B'] was still wearing a depends but it was pushed aside so as to appear it had been removed. Together [RN #4] removed [Resident 'B'] from bed, dressed him, placed him in W/C and placed him at nurses station with CNA. Head to toe performed immediately and incident report initiated. Resident ['B'] was removed from room by approximately 1845 (6:45 p.m.)."			

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	Social Service Progress Notes dated 11/4/11 at 6:55 a.m. indicated: "SS visited [with Resident 'A'] at this time. sitting in chair smiling. This writer inquired as to any concerns voices "No" smiling. Writer inquired as to if she had any visitors last night - smiling voices "No". Writer inquired as if anyone had touched her in anyway inappropriately, voices "No". Writer inquired to if she knew year or day, voices "No" writer inquired as to if she felt afraid of, anyone at facility voices No, No S/S of distress noted - pleasant, smiling...." On 11/17/11 at 3:30 p.m., the Social Services Director indicated Resident 'A' has shown no signs of distress from this incident at any time. A document titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" with an effective date of 10/17/11, was provided by the Executive Director on 11/17/11 at 10:12 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...Sexual Abuse - includes but is not limited to, sexual harassment,			

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	sexual coercion, or sexual assault...1. Any individual who witnesses resident-to-resident abuse will immediately separate the residents involved. 2. The individual who witnessed the abuse will report the situation immediately to his/her supervisor...4. Staff member(s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained...." This federal tag relates to Complaint IN00099853. 3.1-27(a)(3)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure staff reported an allegation of abuse immediately to the supervisor. This deficient practice affected 1 of 5 residents reviewed related	F0225	**F-225 Investigate/ report allegations/ individuals**	12/17/2011

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	155377	A. BUILDING 00 B. WING	11/18/2011

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	to allegations of abuse in a sample of 7. (Resident G) The facility also failed to ensure a resident being abused was protected from further abuse by immediate separation of the abuser (Resident B) from the abused resident (Resident A). This deficient practice affected 1 of 5 residents reviewed related to allegations of abuse in a sample of 7. (Resident A) Findings include: 1. Resident 'G's record was reviewed on 11/18/11 at 12:30 p.m. The record indicated Resident 'G' was admitted with diagnoses that included, but were not limited to, high blood pressure, left sided weakness, insomnia, depression, and anxiety. A quarterly minimum data set assessment dated 10/14/11 indicated Resident 'G' had clear speech, made himself understood, understands others, and had modified independence in cognitive skills for daily decision making. Social Service Notes dated 10/7/11 at 8:40 a.m. indicated: "SS spoke [with Resident 'G'] at this time as to any concerns related to his care. [Resident 'G'] voices, on 10/6/11 around 5PM - he was in bed when a CNA patted his bottom		The facility's intent is to investigate/ report allegations/ individuals. A. **ACTIONS TAKEN**: 1. Employees indicated were suspended and did not return to facility. 2. Resident indicated is no longer a resident at the facility. B. **OTHERS IDENTIFIED**: 1. All residents have the potential to be affected 2. Resident interviews completed to ensure that they felt safe in their home. 3. 100% audit of the behavior monitoring record completed to identify any other residents with sexual behaviors towards other residents or staff. 4. All staff in-service on, abuse prohibition, reporting, and procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS	

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	and asked him if he liked it - resident voices it made him uncomfortable. And he didn't want it to happen again. Resident voices he didn't want any one in trouble, reassurance provided and assured his concern would be investigated...." A care plan, dated 10/7/11, indicated: "Problem: I was patted on my bottom on 10/6/11 it made me feel uncomfortable. Goal: I will be comfortable in my care TNR (through next review) Interventions: (1) Reassure (2) Encourage to vent feelings (3) Notify POA [power of attorney], MD. (4) Resident and POA does not wish to press charges. (5) Calm environment (6) explain procedures prior to care...." A "Facility Incident Reporting Form" indicated: "Brief Description of Incident: [CNA #2] reported during care [CNA #1] patted [Resident 'G'] on the buttocks. Type of Injury/Injuries: None. Immediate Action Taken: [CNA #1 and CNA #2] immediately suspended pending investigation. Preventive measures taken: Shift to Shift 100% all staff inservice on Abuse and Reporting initiated immediately. Results of Investigation: Investigation complete, Staff statements, resident interviews collected. [CNA #2] reported at the end of her shift at 10 pm to nurse that at approximately 4:30 pm she		/SSD or designee with a post test. C. **MEASURES TAKEN**: 1. Any residents identified, care plans / CNA. assignment sheets and current interventions will be reviewed/ updated. 2. All staff in-service on, abuse prohibition, reporting, and procedure as well as implementing appropriate behavior intervention and monitoring scheduled on 12/13/11 by ADNS or designee with a post test, this will be completed on a monthly basis until discontinued by facility QA committee. 3. Audit across all shifts by charge nurse or designee to monitor staff - resident interaction for appropriateness continued until discontinued by CQI committee. 4. All allegations of abuse or neglect will be reported to ED or designee upon occurrence. Investigation will be initiated resident assessments, staff resident interviews, psychosocial monitoring, and updates to plan of care will be completed. Resident physician and family will be notified. Resident safety will be maintained at	

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	witnessed [CNA #1] pat [Resident 'G'] on the buttocks and asked him if he liked it and proceeded to pat him again on the buttocks. After interviewing resident, he did state he did not want it to happen again. Plan of Action/Interventions: [CNA #1 and 2] to both be terminated, and Abuse Inservicing." The facility investigation of this incident included a written and signed statement from LPN #3: "[CNA #2] informed me @ approx. 9:55 p.m. (10-6-11) that she needed to talk [with] me while doing a drsg. change on a resident. After I completed my task, I went to nurse's station and began giving report. Shortly after, [CNA #2] came to door way of nurse's station and stood. I got up and went to her. She began telling me she knew she was suppose to report this. I asked her what was going on. She began by telling me that [CNA #1] had made sexual gestures to [Resident 'G']. Said while they were changing him, [CNA #1] began smacking him on the buttocks. She then asked him if he liked it and when he said yes, she did it again. Said at first it was as if she was joking, then a serious look came over he face. I asked [CNA #2] when this happened and she replied around 4:30 pm that day. I educated [CNA #2] that she needed to report it as soon as it happened so it could be taken		all times. Non compliance with reporting and or protecting may result in disciplinary action up to and including termination. D. **HOW MONITORED**: 1. Resident interviews will be completed to monitor for compliance. Also random employee audits will be completed to ensure staff compliance and understanding of abuse prohibition policy by the SSD/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 2. Any inappropriate behaviors will be reported to the nurse then reviewed in the daily clinical QA meeting. 3. Abuse prohibition and investigation, Abuse prohibition, and psychoactive medication/ behavior management CQI tools will be utilized by CEO/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed.	

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	care of then, do not wait til (sic) end of shift. Told [CNA #2] to write a statement. Took statement and called DON @ that time." A signed statement from CNA #2 indicated: "[CNA #1] made a sexual gesture toward [Resident 'G']. She smacked him on the buttox (sic) while were changing him and asked him "if he liked it"? He then said yes, and she said "oh really, can I do it again then?" And she did. I witnessed this at approx. 4:30 pm." A signed statement from CNA #1 indicated: "I was turning [Resident 'G'] over to change him. And get him ready for bed. Normally whenever I turn him he is screaming and hollering that I am hurting him. Was surprised that last nite [night] he was not doing any of that. I gently patted or tapped his buttocks, & I asked him if I was hurting him. He said no to do it again. I told him no that I wasn't going to do it. But [Resident 'G'] if I am turning you and using the draw sheet to turn you and you are screaming & hollering at me that I am hurting you, why isn't that patting you don't hurt." 2. Resident 'A's record was reviewed on 11/17/11 at 2:31 p.m. The record indicated Resident 'A' was admitted with		4. The Executive Director/Designee will monitor for compliance of audits in the daily QA stand-up meeting. 5. All audit results will be reviewed in the quarterly QA meeting with the Medical Director. **D. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:** **12/17/11.**	

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	diagnoses that included, but were not limited to, hearing impairment, high blood pressure, dementia, mild cognitive impairment, delirium related to multi-etiology, and agitated depression. A quarterly minimum data set assessment, dated 9/26/11, indicated Resident 'A' was able to make self understood and understands others, had minimal difficulty hearing, used a hearing aid, and was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making. Nurse's notes, dated 11/3/11 at 6:35 p.m., indicated: "Called to resident room to find resident ['B'] in bed [with] resident ('A') her pants were down to ankles and his pants were down but depends were on both residents were embracing each other & making movements with their lower bodies. Residents were separated. Resident states she does not know how her pants got down. Male resident thinks she is his wife. Male resident moved to another wing & is on one-to-one supervision head to toe assessment done on [Resident 'A'] vitals wnl (within normal limits) [no] s/s (signs or symptoms) of distress. Male resident had been observed at nurse's station at 1820 (6:20 p.m.)...."			

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	The facility investigation of this incident included a written and signed statement from RN #4: "Was working C-wing with (two CNAs) - [Resident 'B'] on 15 minute checks for recent incident of sexual misconduct [with] female resident was moved to this wing R/T (related to) incident. At 1820 (6:20 p.m.) [Resident 'B'] was at nurses desk observed by nurse & CNA's. I told CNA's was going to take 10 minute break. 7 minutes later was paged by [LPN #5] to C wing. Came back to discover that while CNAs where (sic) laying [another resident] down [Resident 'B'] had wheeled self to [Resident 'A's] room and was in bed with her. Roommate (sic) [name of roommate] went to D wing to get nurse because there was a strange man in bed with her roommate (sic) barking like a dog. [LPN #5] went to the room at 1835 (6:35 p.m.) to find both residents with pants down to ankles. [Resident 'A'] had depend on. I observed both resident's embracing each other with arms & moving lower bodies as if having sex no penetration was observed...we separated resident's and took proper steps to ensure safety. DON [Director of Nursing] & social services all family members notified. Head to toe [assessment] done on both [no] injuries. [Resident 'B'] thought [Resident 'A'] was his wife. [Resident 'B'] was taken to D wing and put on one & one			

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	supervision...." The facility investigation included a written and signed statement from LPN #5 as follows: "On this date at 1835 (6:35 p.m.) I was working as nurse on "D-Wing" when [Resident 'A's roommate] approached me and asked if I was the nurse for "C-Wing". I informed her I was not, but asked what she needed. She then informed me that "There is a strange man in my room and he is in bed with my room mate." I immediately went to room [number of room] where I found [Resident 'B'] laying in bed with [Resident 'A']. I immediately paged "C-Wing nurse [RN #4] to room. Upon arrival to room I found both [Resident 'B' and Resident 'A'] undressed from the waist down. [Resident 'B'] was still wearing a depends but it was pushed aside so as to appear it had been removed. Together [RN #4] removed [Resident 'B'] from bed, dressed him, placed him in W/C and placed him at nurses station with CNA. Head to toe performed immediately and incident report initiated. Resident ['B'] was removed from room by approximately 1845 (6:45 p.m.)." Social Service Progress Notes, dated 11/4/11 at 6:55 a.m., indicated: "SS [Social Services] visited [with Resident 'A'] at this time. sitting in chair smiling.			

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	This writer inquired as to any concerns voices "No" smiling. Writer inquired as to if she had any visitors last night - smiling voices "No". Writer inquired as if anyone had touched her in anyway inappropriately, voices "No". Writer inquired to if she knew year or day, voices "No" writer inquired as to if she felt afraid of, anyone at facility voices No, No S/S of distress noted - pleasant, smiling...." On 11/17/11 at 3:30 p.m., the Social Services Director indicated Resident 'A' has shown no signs of distress from this incident at any time. On 11/18/11 at 10:40 a.m., the Director of Health Services indicated the residents were not immediately separated by LPN #3 when he found them in the same bed, and LPN #3 was terminated. She indicated he was supposed to carry a walkie talkie on him and he didn't have his with him so he had to go out of the room, and left the residents together, while he paged a nurse on another hall. This federal tag relates to Complaint IN00099853. 3.1-28(c) 3.1-28(d)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure staff followed policy and procedure to protect a resident from abuse (Resident A) by immediately removing the abuser (Resident B). The facility also failed to ensure staff followed policy and procedure to report immediately to the supervisor when CNA #2 observed CNA #1 sexually abuse a resident. (Resident G) This deficient practice affected 2 of 5 residents reviewed for abuse in a sample of 7. (Residents A and G) Findings include: A document titled "Abuse Prohibition, Reporting, and Investigation Policy and	F0226	**F-226 Develop/ implement abuse/ neglect, etc policies** The facility's intent is to develop/ implement abuse/ neglect, etc policies. A. **ACTIONS TAKEN**: 1. Employees indicated were suspended and did not return to facility. 2. Resident indicated is no longer a resident at the facility.	12/17/2011

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	Procedure" with an effective date of 10/17/11, was provided by the Executive Director on 11/17/11 at 10:12 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...Sexual Abuse - includes but is not limited to, sexual harassment, sexual coercion, or sexual assault...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers...1. Any individual who witnesses resident-to-resident abuse will immediately separate the residents involved. 2. the individual who witnessed the abuse will report the situation immediately to his/her supervisor...The resident(s) involved in the incident will be removed from the situation immediately...." 1. Resident 'A's record was reviewed on 11/17/11 at 2:31 p.m. The record indicated Resident 'A' was admitted with diagnoses that included, but were not limited to, hearing impairment, high blood pressure, dementia, mild cognitive impairment, delirium related to		B. **OTHERS IDENTIFIED**: 1. All residents have the potential to be affected 2. Resident interviews completed to ensure that they felt safe in their home. 3. 100% audit of the behavior monitoring record completed to identify any other residents with sexual behaviors towards other residents or staff. 4. All staff in-service on, abuse prohibition, reporting, and procedure as well as identifying and monitoring inappropriate behaviors scheduled on 12/13/11 by ADNS /SSD or designee with a post test. C. **MEASURES TAKEN**: 1. Any residents identified, care plans / CNA. assignment sheets and current interventions will be reviewed/ updated. 2. All staff in-service on, abuse prohibition, reporting, and	

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	checks for recent incident of sexual misconduct [with] female resident was moved to this wing R/T (related to) incident. At 1820 (6:20 p.m.) [Resident 'B'] was at nurses desk observed by nurse & CNA's. I told CNA's was going to take 10 minute break. 7 minutes later was paged by [LPN #5] to C wing. Came back to discover that while CNAs where (sic) laying [another resident] down [Resident 'B'] had wheeled self to [Resident 'A's] room and was in bed with her. Roommate (sic) [name of roommate] went to D wing to get nurse because there was a strange man in bed with her roommate (sic) barking like a dog. [LPN #5] went to the room at 1835 (6:35 p.m.) to find both residents with pants down to ankles. [Resident 'A'] had depend on. I observed both resident's embracing each other with arms & moving lower bodies as if having sex no penetration was observed...we separated resident's and took proper steps to ensure safety. DON & social services all family members notified. Head to toe [assessment] done on both [no] injuries. [Resident 'B'] thought [Resident 'A'] was his wife. [Resident 'B'] was taken to D wing and put on one & one supervision...." The facility investigation included a written and signed statement from LPN #5 as follows: "On this date at 1835 (6:35		appropriateness continued until discontinued by CQI committee. D. **HOW MONITORED**: 1. Resident interviews will be completed to monitor for compliance. Also random employee audits will be completed to ensure staff compliance and understanding of abuse prohibition policy by the SSD/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 2. Any inappropriate behaviors will be reported to the nurse then reviewed in the daily clinical QA meeting. 3. Abuse prohibition and investigation, Abuse prohibition, and psychoactive medication/ behavior management CQI tools will be utilized by CEO/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 100% of threshold not met actions plans will be developed. 4. The Executive Director/Designee will monitor for compliance of audits in the daily QA stand-up meeting.	

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SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m.) I was working as nurse on "D-Wing" when [Resident 'A's roommate] approached me and asked if I was the nurse for "C-Wing". I informed her I was not, but asked what she needed. She then informed me that "There is a strange man in my room and he is in bed with my room mate." I immediately went to room [number of room] where I found [Resident 'B'] laying in bed with [Resident 'A']. I immediately paged "C-Wing nurse [RN #4] to room. Upon arrival to room I found both [Resident 'B' and Resident 'A'] undressed from the waist down. [Resident 'B'] was still wearing a depends but it was pushed aside so as to appear it had been removed. Together [RN #4] removed [Resident 'B'] from bed, dressed him, placed him in W/C and placed him at nurses station with CNA. Head to toe performed immediately and incident report initiated. Resident ['B'] was removed from room by approximately 1845 (6:45 p.m.)." Social Service Progress Notes, dated 11/4/11 at 6:55 a.m., indicated: "SS visited [with Resident 'A'] at this time. sitting in chair smiling. This writer inquired as to any concerns voices "No" smiling. Writer inquired as to if she had any visitors last night - smiling voices "No". Writer inquired as if anyone had touched her in anyway inappropriately,		5. All audit results will be reviewed in the quarterly QA meeting with the Medical Director. **D. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:** **12/17/11.**	

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	voices "No". Writer inquired to if she knew year or day, voices "No" writer inquired as to if she felt afraid of, anyone at facility voices No, No S/S of distress noted - pleasant, smiling...." On 11/17/11 at 3:30 p.m., the Social Services Director indicated Resident 'A' has shown no signs of distress from this incident at any time. On 11/18/11 at 10:40 a.m., the Director of Health Services indicated the residents were not immediately separated by LPN #3 when he found them in the same bed, and LPN #3 was terminated. She indicated he was supposed to carry a walkie talkie on him, and he didn't have his with him, so he had to go out of the room, and left the residents together, while he paged a nurse on another hall. 2. Resident 'G's record was reviewed on 11/18/11 at 12:30 p.m. The record indicated Resident 'G' was admitted with diagnoses that included, but were not limited to, high blood pressure, left sided weakness, insomnia, depression, and anxiety. A quarterly minimum data set assessment dated 10/14/11 indicated Resident 'G' had clear speech, made himself understood, understands others, and had modified			

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	independence in cognitive skills for daily decision making. Social Service Notes dated 10/7/11 at 8:40 a.m. indicated: "SS spoke [with Resident 'G'] at this time as to any concerns related to his care. [Resident 'G'] voices, on 10/6/11 around 5PM - he was in bed when a CNA patted his bottom and asked him if he liked it - resident voices it made him uncomfortable. And he didn't want it to happen again. Resident voices he didn't want any one in trouble, reassurance provided and assured his concern would be investigated...." A care plan, dated 10/7/11, indicated: "Problem: I was patted on my bottom on 10/6/11 it made me feel uncomfortable. Goal: I will be comfortable in my care TNR (through next review) Interventions: (1) Reassure (2) Encourage to vent feelings (3) Notify POA [power of attorney], MD. (4) Resident and POA does not wish to press charges. (5) Calm environment (6) explain procedures prior to care...." A "Facility Incident Reporting Form" indicated: "Brief Description of Incident: [CNA #2] reported during care [CNA #1] patted [Resident 'G'] on the buttocks. Type of Injury/Injuries: None. Immediate Action Taken: [CNA #1 and CNA #2]			

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	immediately suspended pending investigation. Preventive measures taken: Shift to Shift 100% all staff inservice on Abuse and Reporting initiated immediately. Results of Investigation: Investigation complete, Staff statements, resident interviews collected. [CNA #2] reported at the end of her shift at 10 pm to nurse that at approximately 4:30 pm she witnessed [CNA #1] pat [Resident 'G'] on the buttocks and asked him if he liked it and proceeded to pat him again on the buttocks. After interviewing resident, he did state he did not want it to happen again. Plan of Action/Interventions: [CNA #1 and 2] to both be terminated, and Abuse Inservicing." The facility investigation of this incident included a written and signed statement from LPN #3: "[CNA #2] informed me @ approx. 9:55 p.m. (10-6-11) that she needed to talk [with] me while doing a drsg. change on a resident. After I completed my task, I went to nurse's station and began giving report. Shortly after, [CNA #2] came to door way of nurse's station and stood. I got up and went to her. She began telling me she knew she was suppose to report this. I asked her what was going on. She began by telling me that [CNA #1] had made sexual gestures to [Resident 'G']. Said while they were changing him, [CNA #1]			

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	began smacking him on the buttocks. She then asked him if he liked it and when he said yes, she did it again. Said at first it was as if she was joking, then a serious look came over he face. I asked [CNA #2] when this happened and she replied around 4:30 pm that day. I educated [CNA #2] that she needed to report it as soon as it happened so it could be taken care of then, do not wait til (sic) end of shift. Told [CNA #2] to write a statement. Took statement and called DON @ that time." A signed statement from CNA #2 indicated: "[CNA #1] made a sexual gesture toward [Resident 'G']. She smacked him on the buttox (sic) while were changing him and asked him "if he liked it"? He then said yes, and she said "oh really, can I do it again then?" And she did. I witnessed this at approx. 4:30 pm." A signed statement from CNA #1 indicated: "I was turning [Resident 'G'] over to change him. And get him ready for bed. Normally whenever I turn him he is screaming and hollering that I am hurting him. Was surprised that last nite [night] he was not doing any of that. I gently patted or tapped his buttocks, & I asked him if I was hurting him. He said no to do it again. I told him no that I			

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	wasn't going to do it. But [Resident 'G'] if I am turning you and using the draw sheet to turn you and you are screaming & hollering at me that I am hurting you, why isn't that patting you don't hurt." This federal tag relates to Complaint IN00099853. 3.1-28(a)			